NEWCASTLE VISION CLINIC
MEDICAL HISTORY FORM

Patient Information

Date: ___________________

Name: ____

Date of Birth: _____________________

What is the main purpose of this visit?

____

____

Date of Last Eye Exam (if elsewhere):_____________________

Name of Family Physician: ______________________________

Location: ____

Do you currently see any other eye specialist? ☐ Yes ☐ No

Name of doctor: _____________________________________

Do you currently wear contact lenses? ☐ Yes ☐ No

Brand used: ____

Solution used: ______________________________________

How often do you replace the lenses: _________________

Patient Eye History

Are you currently experiencing, been diagnosed or treated for any of the following?

- ☐ Cataracts
- ☐ Eye turn/Lazy Eye
- ☐ Eye Infections
- ☐ Flash of light
- ☐ Glaucoma
- ☐ Headaches
- ☐ Itchiness
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Corneal Abrasions
- ☐ Double Vision
- ☐ Eye Injury
- ☐ Floaters/Spots
- ☐ Grittiness/Watery eyes
- ☐ Iritis/Uveitis
- ☐ Trouble Seeing at Night
- ☐ Dry Eyes
- ☐ Sunlight Sensitivity
- ☐ Other Eye Disorders________________________________

Is there a **Family Medical History** of any of the following:

	Yes	Relationship (parent, sibling, etc)
Diabetes	☐	____________________
Hypertension	☐	____________________
Cholesterol	☐	____________________
Thyroid	☐	____________________
Cardiovascular	☐	____________________
Cancer	☐	____________________
Glaucoma	☐	____________________
Cataracts	☐	____________________
Macular Degeneration	☐	____________________
Retinal Problems	☐	____________________
Lazy Eye	☐	____________________
Blindness	☐	____________________

Patient Medical History

Please mark if you have ever been diagnosed or treated for the following health problems

	Yes	Please Explain		Yes	Please Explain
Diabetes	☐	Type:______________	Thyroid	☐	______________
Hypertension	☐	______________	Cardiovascular	☐	______________
High Cholesterol	☐	______________	Cancer	☐	______________
Ears/Nose/Throat	☐	______________	Skin/Integumentary	☐	______________
Respiratory	☐	______________	Neurological	☐	______________
Kidney/Bladder	☐	______________	Psychiatric	☐	______________
Muscle/Bone/Joints	☐	______________	Endocrine	☐	______________
Autoimmune	☐	______________	Blood/Lymph	☐	______________
Digestive/GI	☐	______________	Allergies	☐	______________
Other	☐	______________________________			

CURRENT MEDICATIONS (Rx or Over the Counter) (List medications including eye drops, vitamins, & birth control pills)

____

____

ALLERGIES TO MEDICATIONS (please list names)?

____

Have you had any surgeries (please list type)? ____________________________________

Circle the following used: Cigarettes Tobacco Alcohol Other substances ________________________